Alberta Health Services

Admission Application

☐ Active Rehabilitation Referral ☐ Extended Rehabilitation Referral

- Fax the completed form to **403.625.3051** or mail to **Admissions Coordinator, Claresholm Centre for Mental Health & Addictions, PO Box 490, 139 - 43 Ave West, Claresholm, AB T0L 0T0**
- For further assistance or more information, please call **403.682.3527** or **403.682.3500**

Personal Information			
Last Name		First Name	
Home Address		Present Location	
Phone	☐ Inpatient	Date of Admission *(yyyy-Mon-dd)* _____	
Date of Birth *(yyyy-Mon-dd)*	Gender ☐ Male ☐ Female	Provincial Health Care # *(If out of Alberta, please specify province)*	

Formal Status					
Certificate in effect ☐ No ☐ Yes ► Until *(yyyy-Mon-dd)* _____					
Form 11 ☐ No ☐ Yes		Community Treatment Order ☐ No ☐ Yes			
Goals of Care Designation _____					
Guardian ☐ No ☐ Yes ► ☐ Public ☐ Private					
Name		Address		Phone	
Trustee ☐ No ☐ Yes ► ☐ Public ☐ Private					
Name		Address		Phone	
Personal Directive ☐ Yes ☐ No	☐ In effect ☐ Not in effect	Name			
Address				Phone	
Power of Attorney ☐ No ☐ Yes		Name			
Address				Phone	

Referral Source Information			
Name of Facility/Clinic/Agency		Address	
Contact Person		Contact Psychiatrist	
Phone	Fax	Phone	Fax

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Checklist for Consultation			Please list	History
Substance Abuse	☐ No	☐ Yes ►		
Aggressive Behavior	☐ No	☐ Yes ►		
Legal Issues	☐ No	☐ Yes ►		
Financial Concerns	☐ No	☐ Yes ►		
Housing Needs	☐ No	☐ Yes ►		
Medical Needs	☐ No	☐ Yes ►		
Allergies	☐ No	☐ Yes ►		
Transportation Need	☐ No	☐ Yes ►		

DSM5 Diagnosis

Required Documentation ***(Please attach copies of the following)***

☐ Referral letter from psychiatrist
☐ Current medical history and current treatments
☐ Progress notes for the last 7 days
☐ Psychological reports/testing
☐ Psychiatric assessments, current and historical
☐ Current medication list and patient list with orders
☐ Occupational Therapy Assessments